Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SUGAR LAND SURGICAL HOSPITAL
1211 HIGHWAY 6 STE 70
SUGAR LAND TX 77478-4940

Respondent Name
TEXAS COTTON GINNERS TRUST

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-12-0765-01

MFDR Date Received
November 4, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim was reimbursed incorrectly. Based on Medicare's Methodology plus a markup per Texas OMFS, this claim should have been reimbursed $12,746.48"

Amount in Dispute: $2,234.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the provider is stating they are due reimbursement for the surgical procedure of 27865-LEN/SHRT TEND LEF/ANK; 1 SEP PROC. This code was denied as part of the NCCI edits (National Correct Coding Initiative) as it inclusive of two other procedures being billed. . . . In order for 27685 to be reimbursed the provider would have needed to have billed the modifier 59 and the documentation would have been evaluated to see if it qualified to be paid according to the above criteria. All other reimbursable charges were paid at fee schedule."

Response Submitted by: Forté, 7600 Chevy Chase, Suite 200, Austin Texas 78752

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 27, 2011 to June 16, 2011	Outpatient Hospital Services	$2,234.63	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the

reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 27650 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0051, which, per OPPS Addendum A, has a payment rate of $3,259.30. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,955.58. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of $1,936.42. The non-labor related portion is 40% of the APC rate or $1,303.72. The sum of the labor and non-labor related amounts is $3,240.14. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.205. This ratio multiplied by the billed charge of $12,538.00 yields a cost of $2,570.29. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $3,240.14 divided by the sum of all APC payments is 66.67%. The sum of all packaged costs is $2,039.20. The allocated portion of packaged costs is $1,359.47. This amount added to the service cost yields a total cost of $3,929.76. The cost of this service exceeds the annual fixed-dollar threshold of $2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service, including any applicable outlier payment, is $3,240.14. This amount multiplied by 200% yields a MAR of $6,480.28.
   - Procedure code 27691 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0051, which, per OPPS Addendum A, has a payment rate of $3,259.30. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,955.58. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of $1,936.42. The non-labor related portion is 40% of the APC rate or $1,303.72. The

sum of the labor and non-labor related amounts is $3,240.14. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service, including any applicable outlier payment and multiple procedure discount, is $1,620.07. This amount multiplied by 200% yields a MAR of $3,240.14.

- Per Medicare policy, procedure code 27685 is unbundled. This procedure is a component service of procedure code 27691 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code 64447 is unbundled. This procedure is a component service of procedure code 27691 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Per Medicare policy, procedure code 64446 is unbundled. This procedure is a component service of procedure code 27691 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code 82948 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $4.45. 125% of this amount is $5.56. The recommended payment is $5.56.

4. The total allowable reimbursement for the services in dispute is $9,725.98. This amount less the amount previously paid by the insurance carrier of $10,511.40 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	October 12, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.